

Abstracts

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that are practiced in the hemodinamy service in the Cardiology Hospital "Centro Nacional Siglo XXI" in Mexico City. **METHODS:** Identification of resource use at the hemodinamy service was realized through expert opinion and the revision of hospital records during the first two months of 2005. Unitary costs were obtained from the Accounting Department of the hospital. The intervention's cost estimation was realized with the technique "case mix" and the perspective was that of the Social Security Mexican Institute (IMSS). The direct medical costs included: material of high specialty, medical instruments, drugs, cinefluoroscopy and human resources. Indirect medical costs included: equipment, depreciation, laundry, electricity, telephone, water, etc. Within the estimations of the interventions it was included the use of counterpulsation balloon, cutting balloon, glucoproteins (tirofiban or abciximab) and trombectomy. **RESULTS:** Diagnostic catheterism was estimated in US\$328.7. The cost of the other interventions shifted in function of the type of the stent used (conventional or medical). Intervention of one vessel with conventional stent resulted in US\$1182.5; and with medical stent this raised to US\$3438.5. Also, intervention costs of one vessel trombectomy + counterpulsation balloon + glucoproteins inhibitors resulted in US\$7508.1. An intervention with two left vessel was calculated in US\$10,910.2 and with two left vessel and one right vessel, the cost increased to US\$13,706.7. **CONCLUSIONS:** Our study results showed high direct medical costs heterogeneity on diagnostic procedures in a Mexican hemodinamy service. These results are useful for cost containment policies and for further health economics researches in Mexico.

PCV22

INPATIENT MANAGEMENT OF TRANSMURAL AND SUBENDOCARDIAL ACUTE MYOCARDIAL INFARCTION (AMI): DIFFERENCES IN RESOURCE USE AND COST

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OBJECTIVES: To identify number of transmural and subendocardial AMI cases, as well as related inpatient resource use and cost by type of AMI. **METHODS:** Reported all-payer 2003 hospital data from six states (CA, FL, MD, MA, TX, WA) were analyzed. Transmural (410.00–410.60, 410.01–410.61) and subendocardial (410.70, 410.71) AMI cases were identified using ICD-9 principal diagnosis codes. AMI cases with other (410.80, 410.81) or unspecified (410.90, 410.91) codes were identified, but excluded. Demographics, length of stay, admission source, AMI location, secondary diagnosis and procedure codes, DRG assignment, disposition status and reported charges were analyzed. Charges (accommodations, ancillary services) adjusted by a 0.65 cost-to-charge ratio, and for medical inflation and geographic factors to reflect national values are reported as costs (2005US\$). **RESULTS:** Of the 168,831 AMI cases identified, more than half (56%) were coded as subendocardial ($n = 94,625$). Transmural AMI was coded for 35% ($n = 59,123$); 9% were coded as other or unspecified AMI. The subendocardial AMI group had more females (47% vs. 40%), was older (mean age: 72, median: 75 years vs. mean: 68, median: 70 years), and had a slightly longer LOS (mean: 5.8, median: 4 days vs. mean: 5.5, median: 3.7 days), on average, than those with a transmural AMI. Significantly ($p < 0.01$) fewer patients with subendocardial AMI had ICU days (50% vs. 75%), and percutaneous coronary (47% vs. 27%) and stent (8% vs. 6%) procedures. Coronary-bypass surgery rate was the same (10%) for both groups. Inpatient case fatality rate was significantly ($p < 0.01$) higher for transmural group (10% vs. 7%). The average cost per stay for transmural AMI was \$34,012 (median: \$23,880); \$28,483

(median: \$18,664) for subendocardial AMI. **CONCLUSIONS:** Substantially fewer cases of acute transmural infarct were reported in this dataset. Yet, when reported, they were more lethal, resource intensive and costly than a subendocardial AMI.

PCV23

AN ANALYSIS OF RESOURCE USE IN THE TREATMENT OF DEEP VEIN THROMBOSIS (DVT) IN BRAZIL

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OBJECTIVE: DVT is an important problem in clinical practice. This study aims to estimate the costs of treatment of DVT from the perspective of the private medicine payers in Brazil. **METHODS:** To determine actual costs of patient management the resource use collected during comparative clinical trials often is insufficient. Although large data bases can be used to estimate patient health care resource consumption they are not always available. One reasonable data source is soliciting expert opinion from clinicians. Two Delphi panels one for vascular surgeons, and another for intensivists were performed in order to delineate practice patterns and to obtain resource utilization for routine treatment and monitoring, adverse event management and other clinical parameters representative of community physicians managing of DVT. Responses were obtained from seven vascular surgeons and five intensivists from various centers in Brazil with experience of treating DVT. Percentage likelihood of complications due to thromboprophylaxis was determined based upon physician consensus. A decision analytic model was designed to project the costs associated with venous thromboembolism. **RESULTS:** The detected mean cost (in Brazilian Reais) of DVT was R\$9895.23. The detected cost of diagnosing DVT was R\$74.01, the treatment cost without considering its complications was R\$5208.76 and the complications cost, balanced by incidence was R\$4612.46. The cost to avoid a DVT by the use of a thromboprophylaxis was R\$177.68. **CONCLUSIONS:** DVT costs are only a part of the costs incurred in treating high risk surgical or clinical patients. These results clearly show the substantial costs that a DVT may represent in the treatment of these patients that may be prevented by the use of thromboprophylaxis.

CARDIOVASCULAR DISEASE—Health Care Use & Policy

PCV24

AFRICAN AMERICANS' RESPONSES TO DIRECT-TO-CONSUMER ADVERTISING (DTCA) OF LIPITOR®

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OBJECTIVES: This study was designed to investigate how African American patients respond to DTCA of prescription drug Lipitor® and the relationships between potential influencing variables and patients' responses. **METHODS:** Face-to-face interview was employed for this study, and a convenience sample consisting of 160 African American patients were interviewed at a general medicine clinic in a public hospital. Short-Test of Functional Health Literacy in Adults (S-TOFHLA) was administered to all study participants. Then the participants were asked to view a TV advertisement of Lipitor®, followed by DTCA-related interviews. Patients' demographic and socioeconomic information was also collected during the interviews. Bivariate analyses and logistic regressions were used to assess the relationships between potential influencing variables and patients' responses